Global Waiver Implementation Taskforce
Benefit Redesign Workgroup
Acute and Primary Care Subcommittee
Recommendations
12/4/2009

The Acute and Primary Care Subcommittee was charged with making recommendations to the State regarding:

> How to change the Medicaid benefit package to ensure services provided are the most appropriate and the most cost-effective. Within this workgroup, the focus area will be primary/acute care. This is the system of preventive, primary, acute and post-acute services that are provided through RIte Care, RIte Share, Rhody Health Partners, ConnectCare and/or on a fee-for service basis in hospitals and clinics for in-patient and out-patient services.

The Subcommittee consists of 17 community members and 13 state employees from the following departments: DHS, EOHHS, DCYF, MHRH, HEALTH and RIDE. We met 4 times with about 15-20 people attending each meeting. Draft preliminary recommendations were circulated to the whole committee, and comments were incorporated in this final document.

The Subcommittee operated in an increasingly deteriorating budgetary situation. The Subcommittee makes the recommendations below, knowing that budget constraints will surely dictate the extent to which Medicaid reform can be made.

The Subcommittee agreed on the following overarching principles:

- The Subcommittee supports the DHS goal of finding **the most efficient use of Medicaid dollars in the right place at the right time for the right person across the lifetime.** Any rebalancing, adjustment or modification to the Medicaid program should be mindful of this goal. The Subcommittee believes that patient-centered medical homes are central to this effort.

- The Subcommittee believes that any savings initiatives should first and foremost **improve care**, and at the same time **create Medicaid savings** for the state. Many recommendations will take time to realize savings, but it is believed that most or all of these recommendations will, given time, result in Medicaid savings for the State.

- There was strong consensus among Subcommittee members that **Rhode Island is providing the right benefit package to our Medicaid populations**. The State Medicaid program is not over-providing services. The Subcommittee held its discussions fully cognizant of the difficult fiscal situation of the State. It may

be tempting to cut "optional" services such as adult dental or mental health in order to realize quick savings in a difficult budgetary year. However, the Subcommittee strongly believes that such cuts will not result in real savings across the budget, and might instead defer cost to other line items, such as Emergency Department use. Instead, the Subcommittee believes that the focus of budget-cutting initiatives should be on the delivery system. Changes to the delivery system should be made in collaboration with the community to ensure that the changes will truly result in savings and to guard against the possibility that proposed savings will instead weaken the delivery system and create added expense elsewhere.

- The Subcommittee urges EOHHS and the Departments to understand the **value of preventive supportive services**, including non-medical social supports like housing, which will decrease the utilization of Medicaid services. The Subcommittee believes that **the right approach focuses on comprehensive primary and preventive care with all populations and in all settings**. This focus will help decrease unnecessary medical care and expenditures, and lead to a healthier population that costs less to care for.

The Subcommittee also examined three issues in more depth: (1) the Medicaid delivery system; (2) the overlapping jurisdictions of state agencies; and (3) use of higher acuity services than is necessary or desirable. The Subcommittee's recommendations are below.

Issue: What improvements could be made to the Medicaid delivery system?

Proposed solutions:

- The State should look at the reimbursement system and consider **implementing a pay for performance or shared savings system paired with incentives for providers**. If all payees know what is expected of them, and are held accountable for the care they provide, outcomes can improve while costs decrease. The identification of the performance measures should be a shared task, done with the input of providers and consumers.

- Look to **use the State's purchasing power and financial leverage to increase savings** (e.g. pursue best price negotiations on behalf of the entire Medicaid program).

- Explore whether additional savings could be realized by allowing the Medicaid managed care plans to piggyback on State negotiations with vendors for rates where appropriate.

- **Provide supports, including non-medical supports, to patients**. Often, low-income individuals are faced with multiple urgent needs competing for their time and attention. Parents in a homeless family might understandably be more focused on finding a place to stay than on keeping a medical appointment for their child or themselves. Poor housing conditions might impede family and individual health by increasing risk of injury or exacerbations of chronic illness like asthma. A job search or a visit to the food pantry might trump a preventative care visit to a patient's medical home. These social safety net concerns increase the cost of health care by causing the delay of care until it is more urgent and more expensive. Although providing non-medical supports to low-income patients will require initial and on-going investment of state funds, ultimately it can help reduce overall medical costs to the state. Such supports should be provided in the context of a medical home, in consultation or collaboration with clinical providers or care managers.

- Medical supports, like those found in **patient-centered medical homes** are important, too. A team-based approach that includes patient follow-up, ongoing monitoring of chronic illness and continuity of care are important components of medical homes that help them increase the quality of care to patients and outcomes while reducing costs.

- Look to **recommendations of the Dual Eligible Group** for initiatives appropriate for this population.

- The State should invest in developing patient-centered medical homes through provider incentives and other programs, including taking advantage of the ARRA funds available to support the adoption of electronic health records (EHR).

Issue: Some populations are served by multiple agencies; agencies may not communicate well or effectively.

The Subcommittee spent a lot of time at each meeting discussing the best, most efficient way to ensure that populations touched by multiple departments are being served in the most efficient way possible. Departments discussed included DHS, EOHHS, DCYF, RIDE and Local Education Authorities.

Proposed solutions:

- Over many years, the structure of human services administration has changed in this state, and the use of Medicaid dollars has expanded well beyond one department. It might now be time to **look at expanding the caseload estimating conference to include departments other than**

DHS. Perhaps it would be helpful in making budgetary decisions to include all departments involved in the administration of social services and Medicaid reimbursable services. Such an approach may also provide an opportunity for the conference to see where there may be cost overlap or duplication in budgets.

- Despite all the structural changes among the state departments, there still remains a need for a more systematic approach to coordinated care. The **Departments should coordinate care for patients served by multiple departments, ensuring that the patient has one point of contact and all of the necessary services, with no duplication.** Care should be focused on the needs of the individual patient and his or her family.

- Conceptually, the Subcommittee supports DCYF's approach to keeping families intact and providing the necessary supports to do so. In furtherance of this goal, **all departments, but particularly DCYF, should further explore the barriers to placements in least restrictive environments**. It is important to note, however, that any one department alone cannot control costs, particularly where there are competing authorities and incentives. This must be done in cooperation with the family court and other state departments.

- The Subcommittee discussed that there were often competing incentives to different providers that lead to more costly care at higher levels than might be necessary. For example, a group home might be overly cautious or too quick to send a difficult or ill resident to the emergency room, instead of exploring additional supports that might keep the resident in the home. Emergency rooms have difficulty finding outpatient placements, and hospitals might have incentives (such as financial or liability concerns) to admit a patient who might otherwise be cared for in the community. **Competing incentives should be removed, resulting in cost savings and better care for Rhode Islanders.**

- In order to effectively rebalance incentives so that care is given to patients in the least restrictive environment, and thus reduce costs, the state needs to help **increase community capacity for lower-level treatment of patients across populations**. At the same time, hospitals, providers, judges and schools need to be educated about the availability of out-patient, residential and in-home services that might be alternatives to inpatient placements. Change of this magnitude will require significant changes in culture for many institutions that care for patients with a high level of need, including the courts, hospitals, and schools. In addition, the State should explore other potentially competing incentives for all of these stakeholders and, if necessary, realign them to facilitate this change.

Issue: Unnecessary use of higher acuity services, including Emergency Department.

The Subcommittee discussed that as there is a new advisory committee formed by DHS to look specifically at ED utilization, this Subcommittee would not investigate this arena in depth; nor does the Subcommittee intend to make more specific recommendations relating to ED use. Nevertheless, the Subcommittee makes the following general recommendations.

Proposed Solutions:

- **Increase non-medical patient supports.**
  This Subcommittee discussed the importance of supports for patients, particularly non-medical supports. These supports should be provided with appropriate clinical and administrative management, within the context of a medical home. Housing is a primary support that is needed for patient health. Housing and other supports for patients will in time decrease acute use of medical services, including ED visits. The State should **look to the recommendations of the Housing Workgroup** that address these issues in more detail.

- Patient-centered medical homes improve outcomes and decrease cost. The State should **explore incentives and other programs to assist medical providers so that they establish patient-centered medical homes**.

- The State should **explore the inclusion of integrative medicine as Medicaid supported services**, particularly as options for some of the patients who have costlier, chronic conditions, such as chronic pain. Chiropractic care, acupuncture and other integrative medicine approaches can improve patient outcomes and decrease cost.

- The State should explore the feasibility of a pay for performance reimbursement system, paired with joint incentives for all providers involved in the care of an individual patient. A pay for performance reimbursement methodology makes expectations known to providers, and pays the providers accordingly. It holds providers accountable for results. Incentives should be constructed to help providers provide the best care for the patient, and should counter some market incentives currently in place that cause care to be given to patients at a higher level than necessary in order to obtain the same outcome. The Subcommittee discussed this particularly with respect to group homes/nursing homes/residential placements. The incentives need to help providers

keep residents in their placements, and to avoid unnecessary visits to the emergency department.

Conclusions and future work of this subcommittee

Over the course of our work, the focus of this Subcommittee shifted. Initially the Subcommittee was constituted as an implementation workgroup to advise the State regarding the implementation of the Global Medicaid Waiver. The Subcommittee was, in the end, asked to identify savings initiatives and to respond to the increasing state deficit. The Subcommittee has attempted to meet this change in charge.

Best practice examples exist for each of the policy recommendations made by this Subcommittee. However, with such a broad charge and limited time together, the Subcommittee has limited its recommendations to broad policy recommendations. The Subcommittee would be pleased to continue our work, should the State find it helpful, to delve more deeply into any one of the areas addressed in these preliminary recommendations and to identify best practices that could work in Rhode Island.

The Subcommittee would reconvene to continue its work should it be useful and important to the State. However, that decision should be made while considering how best to use the time of the Subcommittee members and State staff. Since the time this group was formed as a Subcommittee of the Global Waiver Implementation Task Force, the State has convened at least two additional advisory committees with overlapping membership and overlapping charges: the Emergency Department Advisory Committee and the Modernization Committee. The Subcommittee recommends that its time could be best used to review waiver initiatives regarding Medicaid benefits and to comment on them before implementation.

Respectfully submitted,

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Subcommittee Chairperson

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